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Post-Traumatic Stress Disorder

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# THE TREATMENT OF ACUTE TRAUMA

## Post-Traumatic Stress Disorder Prevention

Tom Lundin, MD, PhD

. . . for I was an hungred, and ye gave me meat;  
I was thirsty, and ye gave me drink;  
I was a stranger, and ye took me in;  
Naked, and ye clothed me;  
I was sick, and ye visited me;  
I was in prison, and ye came unto me.

ST. MATTHEW 25:35-37

Our knowledge of the importance of having a holistic view of humans is based on the Judeo-Christian moral concept—especially concern for relieving human suffering. The possibilities to help psychologically traumatized people effectively imply sufficient medical and psychological knowledge of normal and pathologic conditions as well as good insight into oneself and empathetic skills.

It is not quite clear that it is possible to prevent post-traumatic stress disorder (PTSD) by means of early psychological support, counseling, or psychotherapeutic treatment. Biologic and psychological risk factors might interfere with different kinds of treatment efforts. It is, however, a basic human duty to try to help our fellow human beings. Fortunately, a first step has been taken in that direction by the creation and description of the new category, *acute stress disorder*, in DSM-IV.

### GENERAL ASPECTS

Psychological traumas affect people in different ways. Victims of individual traumas as well as following disasters might be helped primarily by self-help

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and peer support, the social network, and volunteers and secondly by primary health care, nursing care, social service, pastoral care; crisis intervention centers; psychiatric care; and centers for PTSD or traumatized persons.

Psychological and medical care has different levels. Information and counseling are always important for people exposed to traumatic stress. The information has to be adequate, honest, unambiguous, and timely. A proper amount of information has to be given at the right time. If the traumatic situation is protracted, the information must be given in "appropriate dosage" and be sensitive to the victim's ability to assimilate it.

Psychological support, crisis intervention, defusing, debriefing, and other psychotherapeutic methods as well as psychopharmacologic treatment are often needed for victims of disasters or traumatic stress. It is of great importance to provide the victims a feeling of security and confidence while informing about acute treatment and follow-ups. It is also important to determine the need for psychological and medical help based on the assessment of the persons at risk, risk situations, and risk behaviors.

### ROLE OF TREATMENT STRATEGIES

Assess early the need for support or psychological/psychiatric interventions following a traumatic stress. The two most important factors for a proper assessment of the adequate treatment methods are the degree of psychological over-determination and the degree of traumatization (type of traumatic event).

1. When a person has been affected by a minor traumatic event and when the psychological reaction is not overdetermined, there generally is no need for counseling or crisis intervention besides peer and social network support.
2. If the same person experiences a severe traumatic event (e.g., a mass casualty or disaster), he or she will certainly need temporarily extra support from friends and sometimes counseling from experts.
3. When there is a high degree of overdetermination, even normal life events might raise the need of psychotherapeutic intervention, medication, and sometimes hospital care.
4. The experience of a serious, sudden traumatic event and a high degree of overdetermination often result in a primary need of psychiatric care and medication and later on psychotherapeutic interventions.

### RITUALS

Magical thinking, customs, and rituals in all cultures have had an important protective function for the individual in strengthening the psychological defense mechanisms against fear and anxiety. Rituals are manifestations of both needs and psychological defense strategies in the mourning process. The grief reaction is also strongly influenced by the cultural pattern. The historical perspective is necessary for understanding customs and rituals that typically flow from rules and instructions. Customs and rituals often promote a feeling of safety and confidence for the traumatized person in a situation of inner psychic chaos. The rite might lessen the anxiety of the grief reaction in explaining the uncomprehensible through concrete and symbolic acts and can be a comfort for the bereaved. Rituals also provide for collective support and relief from and with others through expression of feelings.

## PSYCHOLOGICAL METHODS

Information and educative interventions as well as "emotional first aid," counseling, support, and crisis interventions, when used in combination, sometimes are effective in preventing PTSD. Focused short-term psychotherapy may also be effective.<sup>13</sup>

### Information

Careful, detailed information about a trauma is of great importance, particularly shortly after the traumatic event. The information often has to be repeated several times, owing to a reduced capacity for perception during the shock phase. The information should be concrete and free from euphemisms and attempts to cover or withdraw psychologically painful or unpleasant details because this might prevent the victim from developing unnecessary and frightening fantasies about what has occurred or what the injured and dead looked like. This information is especially important for close relatives: They need a basis in reality as a ground for psychological working through.

Also, a realistic hope has to be supported through the way information is given. This makes it possible to cope with the psychic pain and the threat of loss. Unrealistic hope should be counteracted by giving realistic answers to both the expressed and the unexpressed questions. The traumatic information has to be given with great care.

### Psychological Support

Good support strengthens ego functions and contributes to better coping. The victim should be helped to appreciate his or her own responsibility for successful coping. This might also change the patient's perspective from being a victim to a survivor. Psychological support is generally well integrated into everyday care.

### Crisis Intervention

Crisis intervention following traumatic stress should be early, brief, and problem-focused. It should aim to restore distressed individuals to a precrisis level of functioning.<sup>9</sup> Crisis intervention as a formal method for helping traumatized persons has been reported on at length by several authors.<sup>1, 2, 4-6, 9-11, 14-16, 18-25</sup>

### Emotional First Aid

Caplan<sup>5a</sup> describes the basic principles for emotional first aid as psychological and social preventive work and emphasizes that early intervention for people traumatized in a war situation is essential. There are four common intervention principles:

- Proximity: the patient should be treated as close as possible to the place where his or her breakdown occurred.
- Immediacy: the treatment should be initiated as quickly as possible.

Expectancy: the patient is expected to recover quickly.

Simplicity: the treatment method should be as simple as possible.

Toubiana et al<sup>22</sup> have described a school community-based primary and secondary crisis intervention program with 415 children in the seventh grade and their teachers during an acute bereavement reaction to the death of 19 schoolmates and the critical injury of 14 others in a school bus accident. The four intervention principles were reinterpreted and applied to dealing with the stress reactions of these children and their teachers.

The principles for emotional first aid have been further elaborated to address mass casualties and disasters:

- Acceptance of feelings.
- Acceptance of symptoms.
- Identifying resources and activities.
- Realizing psychologically painful situations.
- Acceptance of reality.
- Optimistic attitude.
- Avoid blaming others.
- Acceptance of help/support.
- Resume activities of daily life.

### Psychotherapy

Immediate, problem-oriented, and structured short-term psychotherapy may be of great value to prevent PTSD. A large-scale study of the effectiveness of psychotherapeutic methods for the treatment of PTSD was conducted. The sample consisted of 112 persons suffering from serious disorders resulting from traumatic events (bereavement, acts of violence, and traffic accidents) that had taken place not more than 5 years before. Trauma desensitization, hypnotherapy, and psychodynamic therapy were tested for their effectiveness in comparison with a waiting-list control group. The results indicated that treated patients experienced significantly less trauma-related symptoms than the control group.<sup>3</sup>

The results of brief psychodynamic psychotherapy of 30 survivors of the Beverly Hills Supper Club Fire in 1977 have been reported.<sup>17</sup> The treatment was conducted approximately 1 year after the disaster. Independent judges rated the therapy in terms of completion: 5 nonengaged, 15 interrupted, 10 completed. Factors such as degree of traumatic symptoms, length of therapist experience, and degree of acculturation to the particular disaster affected completion of therapy. At an individual level, completion was influenced by the management of nodal points in the treatment: engagement, dosing of affect, management of the transference, and termination. As measured by standardized instruments, survivors with completed treatment showed considerable improvement at 3 months, whereas the interrupted group showed no change.

In 1985, two unusual events took place in Denmark. In March, six civilians, three policemen, and three interpreters (female) were taken as hostages by Lebanese refugees, and in August, two bombs exploded in Copenhagen. One was placed outside an American airline office, the other at a synagogue. Until then, Denmark had been basically unaffected by such violence and terror that had swept through Europe and other places in the world in the years previously. The two bomb explosions in particular shocked the population. Terror was now on Denmark's doorstep. The six persons who were taken hostage were held by their

captors for about 5 hours and were exposed to threats on their lives. After their release, they were flown directly to the University Clinic, where they underwent treatment together in a group. The only part of the Stockholm syndrome that developed during the hostage incident was the anger and distrust shown toward the authorities by the group. The group members met seven times and at the trial following the incident were given compensation but not equally. This had a disastrous effect on the hostage group, which subsequently split up. Only on one occasion after the trial was it possible to assemble the entire group again. The group psychotherapy offered to the hostages gave them ample opportunity to share and work through their joint experience.<sup>24</sup>

### Psychopharmacologic Treatment

Traumatic stress sometimes, through the phenomenon of unrepression, reactivates earlier psychiatric problems. The symptoms, especially those related to psychophysiologic changes, sometimes reflect normal reactions that are so painful that pharmacologic treatment is essential. It is important to use drugs that do not interact with the capacity for psychological working through. For example, it is generally advisable to avoid the frequent or regular use of benzodiazepines. Both tricyclic and selective serotonin reuptake inhibitor (SSRI) antidepressants, however, have been used successfully in treating acute stress reactions and PTSD.

Fluoxetine was given to five nonveteran patients with PTSD. The maximum doses ranged from 20 to 80 mg/day, and treatment was continued for between 8 and 32 weeks. In contrast to published reports of other drugs, which were noted to improve only the intrusive symptoms of PTSD, fluoxetine was associated with marked improvement of both intrusive and avoidant symptoms. Facilitative effects of fluoxetine were noted on trauma-focused psychotherapy in two adult victims of childhood sexual trauma. In part, these effects were related to modulating effects of the drug on the intensity of core PTSD symptoms. Serotonergic drugs appear to hold promise for the broader treatment of PTSD.<sup>8</sup>

In a double-blind, randomized, clinical trial, the efficacy of imipramine and phenelzine was compared with that of placebo in 34 male veterans with PTSD. Both medications reduced PTSD symptoms.<sup>12</sup>

Amitriptyline hydrochloride was compared with placebo in 46 veterans with chronic PTSD. Treatment continued up to 8 weeks, and efficacy was measured by five observers and two self-rated scales. Percent recovery rates were higher for amitriptyline than placebo on two measures. In patients who completed 4 weeks ( $N=40$ ), better outcome with amitriptyline was noted on the Hamilton depression scale only. In the group completing 8 weeks of treatment ( $N=33$ ), the drug was superior to placebo on Hamilton depression, Hamilton anxiety, Clinical Global Impression severity, and Impact of Event scales. There was no evidence for drug effects on the structured interview for PTSD. Drug-placebo differences were greater in the presence of comorbidity in general, although recovery rates were uniformly low in the presence of major depression, panic disorder, and alcoholism. At the end of treatment, 64% of the amitriptyline and 72% of the placebo samples still met diagnostic criteria for PTSD.<sup>7</sup>

### Psychiatric Risk Groups

One of the most important tasks for the psychiatrist in the aftermath of a traumatic stress situation is to identify those victims who are at risk for devel-

oping PTSD or other types of stress-related psychic or psychosomatic disorders. The following risk groups should be actively followed up:

1. Survivors with psychiatric disorders.
2. Close relatives to suddenly or traumatically deceased persons.
3. Children, especially when separated from parents.
4. Persons who are especially dependent on a psychosocial stability: elderly, handicapped persons, or mentally retarded.
5. Traumatized survivors.
6. Body handlers.

Besides identifying these risk groups, it is important to identify risk behaviors, symptoms, or signs that might be the first indication of a pathologic development of the traumatic stress reaction.

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